

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

Primary Registration District No.

Registrar's No.

318 1003 11519-63-046021

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

Inside Limits

Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)

Inside Limits

d. STREET ADDRESS (If outside, give location)

Reside on Farm

Yes ☐ No ☒

3. NAME OF DECEASED

First

Middle

Last

Month

Day

Year

(Type or print)

MABLE

(FOSTER)

SCOTT

DATE OF DEATH

NOV.

18

63

5. SEX

6. COLOR OR RACE

7. Married ☒ Never Married ☐

8. DATE OF BIRTH

9. AGE (last birthday)

IF UNDER 1 YEAR IF UNDER 24 HR

FEMALE

NEGRO

Widowed ☐ Divorced ☐

6-1-05

58

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

12. CITIZEN OF WHAT COUNTRY

HOUSEWIFE

M'KENZIE, TENN.

U. S. A.

13a. FATHER'S NAME

13b. MOTHER'S MAIDEN NAME

14. NAME OF HUSBAND OR WIFE

ERIC HAMILTON

INEZ DRAKE

WM. H. SCOTT

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

(Yes, no, or unknown) (If yes, give war or dates of service)

WM. H. SCOTT

1205 OAKLEY

18. CAUSE OF DEATH (Enter only one cause per line)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Fracture of hip, Atherosclerosis

INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Supposed in fall on or about October

DUE TO (c)

7th 1963, at Chronic Hospital 5600 Arsenal.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

904.7-45

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☒ Unknown

19. WAS AUTOPSY PERFORMED?

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

YES ☐ NO ☒

☒

☐

☐

See above

20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

?

10-7-63

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

Hospital 13

St. Louis, Mo.

21. I attended the deceased from

to

and last saw her

him alive on

Death occurred at

4-6 A

m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

11-18-63

1300 Clark

11-18-63

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

REMOVAL

11-22-63

GREENWOOD CEM.

ST. LOUIS CO.

MO.

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

PETTIS MORTUARY 4181 WASHINGTON

NOV 21 1963

Boad Smith, M.D.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Esther K. Harris*

Licensed Embalmer No.

*4458*

P. O. Address

*4181 Washington*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.